U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

Inmate Name	Register Number	Date
Santiago Ernie	90304-038	10-6-05
	Date of Birth	Social Security Number
	8-6-72	

I hereby authorize and request the Federal Bureau of Prisons to:

X release information to, or ☐ obtain information from

PLEASE CONTACT IF PAYMENT IS REQUIRED PRIOR TO FILLING REQUEST

Name/Facility: Arlene Spector

Address: _____

City, State, Zip: _____

I understand the information is to be used for (specific reason for release of information):

☐ Continuation of care, or ☐ Other Correspondence

Information to be Released/Obtained: Copy of and/or information from my medical file pertaining to my evaluation and treatment received from _____ to _____.

This is to include:

☐ Complete Record & Physical ☐ Discharge Summary ☐ History

☐ Operative Reports ☐ Consultations ☐ Progress Notes ☐ X-ray Reports

☐ Laboratory Reports ☐ Pathology Reports ☐ Actual Films*# ☐ Actual Slides*

☐ Other: _____

*will be returned
#duplicates accepted

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I understand that I may revoke this consent at any time by sending a written notice to the Supervisor of Medical Records. I understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. This authorization will automatically expire three months from the date of the signature.

Signature of Patient	Date (Month, Day, Year)	Staff Witness
X Ernie Santiago FAX SIGNATURE VALID ORIGINAL	10-6-05	D. Tamm, HIT

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW.
Must sign below, to Release Protected Information.

I specifically authorize the release of data and information relating to:

☐ 1. Substance Abuse ☐ 2. Mental Health ☐ 3. HIV

_____ _____
Signature Date

FCI MCKEAN, P.O. BOX 5000, BRADFORD, PA 16701 Fax No.: (814) 363-6813

Exhibit D

[redacted]

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